

wealth, Welfare public service

300 -57

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION
Doctor, coroner, etc. must use only standard nomenclature in item 18. All diseases in Part I must be causally related.

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-006259
STATE FILE NUMBER

FILED FEB 25 1958

Registration District No. 170 Primary Registration District No. 3033 Registrar's No. 25

1. PLACE OF DEATH a. COUNTY <u>Laclede</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Camden</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Lebanon</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Stoutland</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Long Rest Home</u>		Length of stay in 1b <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Rural</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Robert L. Ford</u>			4. DATE OF DEATH Month Day Year <u>Feb. 13, 1958</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 24, 1869</u>
9. AGE (In years from birthday) <u>88</u>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Carrollton, Mo. U. S. A.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13a. FATHER'S NAME <u>John Ford</u>	13b. MOTHER'S MAIDEN NAME <u>Elizabeth Montague Nannie</u>
14. NAME OF HUSBAND OR WIFE <u>Mrs. Marie Babler</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	16. SOCIAL SECURITY NO. <u>none</u>
17. INFORMANT <u>4200</u>		Address <u>Kansas City, Mo.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>chronic myocarditis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>arteriosclerotic heart disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		20c. TIME OF INJURY Hour Month, Day, Year o.m. p.m.	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
21. I attended the deceased from <u>2-4-58</u> to <u>2-13-58</u> and last saw ^{him} alive on <u>2-12-58</u> Death occurred at <u>9:50 AM</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>R B Hunt M.D.</u>		(Degree or title)	22b. ADDRESS <u>Lebanon, Mo.</u>
22c. DATE SIGNED <u>2-15-58</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
23b. DATE <u>2/16/58</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Stoutland Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Stoutland, Mo.</u>
24. FUNERAL DIRECTOR <u>Halman Lebanon, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>2-16-1958</u>	26. REGISTRAR'S SIGNATURE <u>Hella L. Hays</u>

Received FEB 23 1958
Laclede County Health Unit
File No. 25
Date Filed FEB 23 1958

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed Dorsey M. Howe
Licensed Embalmer No. 4222
P. O. Address Lebanon, N

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.